Annual Wellness Visit

First Name	Last Name	Date of Birth

Annual Wellness Visit (AWV). Did you know?

At Brio Primary Care, we pride ourselves in offering the best healthcare possible to our patients. By doing this, our Providers, in keeping with Medicare guidelines, are requiring all Medicare patients at Brio Primary Care to partake in an AWV.

What are the benefits of an Annual Wellness Visit?

1. The AWV is a benefit of Medicare.
2. The AWV helps to provide preventive care to our Medicare patients.
3. The AWV allows you to spend more time with your Provider.

What am I to expect during my Annual Wellness Visit?

1. Collection of personal, medical, and surgical history, a list of current medications, vitamins, and supplements taken, and any other doctors who are involved in your care.
2. Depression and mood disorder screening.
3. Review of functional abilities and level of safety (i.e. fall risk, hearing loss).
4. Lab draw for you to discuss at your next visit with your Provider.

I acknowledge that, as a Medicare patient of Brio Primary Care, it is best practice to participate in an Annual Wellness Visit each year. The AWV will better help my Provider to care for me and to meet my medical needs. I understand that refusing to participate in a yearly AWV may result in my dismissal as a patient from Brio Primary Care.

Patient Signature	Date Completed

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Please complete the questions below prior to seeing your medical assistant or nurse. Your responses will help us give the best healthcare possible.

Patient Information

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

In a Relationship with a: Male Partner ☐ Female Partner ☐ N/A ☐

How many biological children do you have? _____

Employment Status: Employed ☐ Retired ☐

Risk

Do you *currently use* tobacco products? Yes ☐ No ☐

Have you *ever used* tobacco products? Yes ☐ No ☐

How often do you exercise? _____

How often do you wear your seatbelt? _____

Are you sexually active? Yes ☐ No ☐

Do you experience sexual problems? Yes ☐ No ☐

Do you experience bladder control / leakage problems? Yes ☐ No ☐

Do you have difficulty with your hearing? Yes ☐ No ☐

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General Health

In the past month, have you experienced pain? Yes ☐ No ☐

How would you describe the ease in which you can do the below?

Please check the box with the option that best applies to you.

	Easy	Somewhat Difficult	Very Difficult	I am Unable to
Prepare Food	☐	☐	☐	☐
Bathe / Clean Yourself	☐	☐	☐	☐
Dress Yourself	☐	☐	☐	☐
Use the Restroom by Yourself	☐	☐	☐	☐
Do Your Own Shopping	☐	☐	☐	☐
Pay Your Own Bills	☐	☐	☐	☐
Do Routine Housework	☐	☐	☐	☐

Fall Risk and Home Safety

How many times have you fallen within the past year?

☐ No falls ☐ One fall without injury ☐ One fall with injury ☐ Two or more falls without injury ☐ Two or more falls with injury

Do you feel unsteady when standing or walking? Yes ☐ No ☐

Are you worried about falling? Yes ☐ No ☐

Do you feel safe in your current home? Yes ☐ No ☐

How often do you spend time with others? None, I prefer isolation ☐ Occasionally ☐ Frequently ☐

Do you wear hearing aids? Yes ☐ No ☐

Do you wear glasses? Yes ☐ No ☐

Who do you live with? _____

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When was your last…

Exams:

Exam Type	Date
Dental	
Eye	

Screenings:

Check this box if there are no changes since your last visit ☐

Screening Type	Date
Colonoscopy	
Cologuard	
Abdominal Aortic Aneurysm	
For Females Only:	
Pap Smear	
Mammogram	
Bone Density	
For Males Only:	
PSA	

Vaccines

Check this box if there are no changes since your last visit ☐

Vaccine Type	Date
Pneumonia	
Influenza (Flu)	
Hepatitis B (series of 3)	
Shingrix	
TDAP	
COVID-19	

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Do you see any other specialists?

Specialist *Example: Cardiology*	**Practice / Provider Name** *Example: PRISMA*

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SBIRT (2018 Edition)

Alcohol Use

How often do you have a drink containing alcohol?

☐	☐	☐	☐	☐
Never	Monthly Or Less	2 - 4 Times A Month	2 - 3 Times A Week	4 or More Times A Week

How many drinks containing alcohol do you have on a typical day when you are drinking?

☐	☐	☐	☐	☐
1 or 2	3 or 4	5 or 6	7 or 9	10 or More

How often do you have five or more drinks on one occasion?

☐	☐	☐	☐	☐
Never	Less Than Monthly	Monthly	Weekly	Daily or Almost Daily

Drug Use

How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?

☐	☐
0	1 or More

Total Count: _____

This screening form is a health evaluation measure we are required to have you complete once a year at your annual exam. Your insurance will be billed for this form as a part of your visit today.

Updated 10/2025

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Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at All	Several Days	More than Half of the Days	Nearly Every Day
1. Little Interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

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Social History Question

Does a partner, or anyone at home, hurt, hit, or threaten you? Yes ☐ No ☐